Ambulance Billing FAQ

FAQs compiled from the Ambulance Billing Presentation Webinar held Tuesday, July 20, 2021

Q: If the patient has Medicare as the primary insurance, is a denial from Medicare needed before billing Medicaid for A0998?

A: As with all other insurance plans, Medicare is considered primary and must be billed first. Providers should report the corresponding Claim Adjustment Reason Code (CARC) regarding the denial or payment to Medicaid as the payer of last resort. Without the other insurance information, the claim will deny.

Q: Is it common practice for Medicaid to suspend air ambulance claims for an extended time for review?

A: Most claims that require manual review can suspend for up to 90 days for claims processing. If a provider has a claim that has been suspended for more than 90 days, please contact Provider Support at 1-800-292-2550 or by email at ProviderSupport@michigan.gov.

Q: When billing to Medicaid fee for service for psychiatric-related transport services we often get claim denials. Is there specific information we should be aware of to get these claims paid?

A: Medicaid allows certain psychiatric diagnosis codes to be reimbursed. Providers should be sure to verify the beneficiary has Medicaid eligibility for the date(s) being billed, ensure their claim is coded correctly, and ensure appropriate transport codes are reported. If you believe the claim was denied in error, please contact Provider Support for assistance.

Q: If a patient shows an incarcerated status in CHAMPS for the date of service they are transported, but are not actually in custody on that date, is there a way to bill and show the patient was not in jail?

A: This is an eligibility issue. Providers with this issue should contact Provider Support to verify beneficiary eligibility and updated if needed.

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Q: Is there a modifier for death?

A: There is no modifier for death. In situations where a Medicaid beneficiary dies, reimbursement to a Medicaid ambulance provider depends upon when the beneficiary's death occurs. If a beneficiary is pronounced dead by an individual legally authorized to pronounce death:

- Prior to the time that the ambulance is called, no payment is made.
- After the ambulance is called, either before or after the ambulance arrives at the scene, payment for an ambulance trip is made at the BLS rate, but no mileage is paid.
- On arrival to the receiving hospital after getting medically necessary care during the ambulance transport from the scene to the receiving facility, payment is made at the medically necessary level of service furnished.

Q: Any time I put a modifier in, it won't let the claim be submitted. Where should the modifier go?

A: If entering a claim via direct data entry into CHAMPS, modifiers should be entered in the basic line item section of the claim. However, if submitting through your software vendor, when reporting a modifier along with other insurance please report the modifiers in the SVD segment of Loop 2430 and at the line level (Loop 2400) on secondary and tertiary claims it has to be in both areas.

Q: Is the emergency indicator only supposed to be reported for out-of-state transports?

A: The emergency indicator must be reported on all emergency transport claims that are submitted on the institutional or professional 837, regardless if the transport is out of state.

Additional Resources

- Ambulance Billing Recording: https://somdhhs.adobeconnect.com/p0zoxi906gum/
- Provider Support
  - Phone: 1-800-292-2550
  - E-mail: ProviderSupport@Michigan.gov
  - Webpage: www.Michigan.gov/MedicaidProviders
  - 1-on-1 Appointment Request
- Medicaid Provider Alerts: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78458---,00.html